STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

P.O. Box 45500. Olympia. Wasliinyton 9S504-5500

April 12, 2004

Ms. Juli Harkins, Project Officer
Centers for Medicare and Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21224-1850

Dear Ms. Harkins:

Under the Special Terms and Conditions (STC) of the Medicaid demonstration waiver Project No. 11-W-OO 180/0, agreed to by the State of Washington in our letter to Dennis Smith on March 26,2004, we are submitting a description of the waiver Operational Protocols. The STC dictate that you will respond to our submittal within 30 days of receipt. The description is due May 1, however we want to allow adequate time to resolve questions you may have and start the project on time, July 1.

Because waiver planning and systems design have been in progress since 2001, much of our description is dedicated to waiver activities complete to-date, rather than how we plan to implement the program. Everything is in place to initiate the program July 1, and the bulk of our activity will shift to the actual start of the premium program, monitoring operations and outcomes, reporting on waiver activity, and laying the groundwork for the evaluation.

Enclosed are the description of Operational Protocols and attachments. No later than May 1, 2004, and under separate cover, we will be sending our proposed evaluation design and our argument for allowing an exemption from the waiver for American Indian and Alaska Native children.

Our primary contact for the demonstration project will be Roger Gantz, Director of the Division of Policy and Analysis in the Medical Assistance Administration. Contact information is as follows:

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If you have questions or comments, please contact Mr. Gantz directly.

Sincerely,

Douglas Porter Assistant Secretary
Medical Assistance Administration

Enclosures

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
WASHINGTON MEDICAID REFORM WAIVER (11-W-00180/0)
OPERATIONAL PROTOCOL

Assurances

The Department of Social & Health Services (DSHS) Medical Assistance Administration (MAA) will schedule calls with CMS, before implementation and monthly thereafter, to discuss waiver implementation progress. Primary contact between CMS and DSHS on waiver implementation and evaluation will be Roger Gantz, Director of the Division of Policy & Analysis.

The Washington State legislature authorized implementation of the premium program, in its current configuration, in the session that ended March 11, 2004. DSHS requires time for quick systems changes to initiate the program and to send advance and adequate notice to the clients who are affected. As mentioned in our March 15 letter to Dennis Smith, MAA is requesting that the waiver start date be moved to July 1,2004, and that premiums be assessed only on those clients in families with income above 150% of the federal poverty level. MAA will submit quarterly and annual reports, beginning with the July-September 2004 period, within the 60 days allowed.

The final report and the program evaluation are expected to be available within 180 days of the end of the waiver.

Organization and Structural Administration

DSHS is an umbrella social service agency serving over one million clients per year, providing assistance ranging from Medicaid and TANF to juvenile rehabilitation. (See attached agency organization chart - Attachment A.) DSHS is the designated single state agency for Title XIX, and within the agency, the MAA has primary responsibility for the Section 1115 premium demonstration.

MAA will rely on other administrations within DSHS for premium program implementation and on-going operations, but oversight will reside in MAA.

The Economic Services Administration (ESA) will be responsible for computing premiums due, terminating clients for non-payment of premiums and answering questions from clients. The computation of premiums is a function of the Automated Client Eligibility System (ACES) within ESA. The planning and design for programming in ACES was initiated in 2002, anticipating that the waiver would be approved in 2003. All testing has been done, and the system is set to initiate the premium program July 1, 2004.

Advance notice will be initiated by the Division of Customer Support within MAA, via a letter generated in ACES and mailed to affected clients (those who will need to pay a premium for a child) the week of June 14th. At the end of June, the Financial Services Administration's (FSA's) Office of Financial Recovery (OFR) will send out the first premium invoices to all households who must pay a premium in July. Every month, ACES will generate premium information that will be sent to OFR. OFR will mail premium notices to clients, collect premiums, track payments, and notify ACES when a client is to be terminated for non-payment of premiums.

MAA will be responsible for quarterly status reports, the evaluation, and act as the primary contact with CMS on the project. FSA is responsible for preparation of the CMS 64 and CMS 37 reports. MAA will coordinate with FSA and CMS Region X to assure proper reporting. A summary of responsibilities is as follows:

Medical Assistance Administration (MAA):
- Division of Policy & Analysis (DPA)- waiver development, quarterly status reports, evaluation development, primary contact with CMS
- Division of Client Support (DCS)- implementation policy and procedures, client educational materials including website

Economic Services Administration (ESA)
- Community Services Division (CSD) - Community Services Offices (CSOs) - staff determines eligibility according to all rules of the Washington Administrative Code and the Title XIX State Plan
- Automated Client Eligibility System (ACES) - Department staff programmed automated support for premium calculation and interfaces with FSA/OFR for billing.

Financial Services Administration (FSA)
- Office of Financial Recovery (OFR) - Designed billing invoice and has responsibility for billing and accounts receivable
- Office of Accounting Services (OAS) - CMS 64 report
- Office of Budget and Forecasting - CMS 37 report

Management Services Administration
- Research and Data Analysis Division (RDAD) - development of waiver evaluation design

Reporting Items

To implement the reporting of the 1115 Demonstration waiver collection of premiums for CN - Optional (CN-0) children with family incomes above 150 percent of FPL, OAS will need to accomplish two major objectives. The first objective will be to develop the ability to properly apply the premiums as an offset to the Title XIX expenditures incurred for the clients served. This ability has been established through the Client Accounts

Receivable System (CARS) in OFR. OAS has developed the correct account coding for this system to both offset the expenditures in the accounting records and, through the use of a unique identifier in the chart of accounts, identify the premiums separately on the CMS 64.

Staff in CMS Region X, DSHS and CMS in Baltimore have agreed that premiums will be reported on Line 9E, Collections - Misc. The state of Washington does not currently report anything on that line, and this would provide an easy way to separately identify the waiver premiums.

The second objective is to set up the appropriate mapping criteria in the department's Title XIX claim system that will allow us to identify and report the expenditures for waiver clients, by service, on the appropriate 64.9 waiver and 64.10 waiver forms. This will require coordination between OAS, CMS Region X and MAA. Currently the needed waiver form is not in the MBES system that DSHS uses to report waiver activity. DSHS has informed CMS Region X that the MBES needs to be updated and Region X is working on this.

Premiums

The proposed premium amount is $10.00 per month per child, up to a maximum of three children, when the assistance unit's (AU's) net available income is above 150% FPL and at or below 200% FPL. To determine net income, DSHS uses the income available to the assistance unit and then applies certain deductions. The same net available income amount used to determine eligibility for the AU is compared to the FPL corresponding to the size of the AU. An optional child is billed the premium amount accordingly.

Enrollees have received an informational insert mailed with the medical ID card (see Attachment B). DSHS will send an additional informational mailing before premiums are implemented. MAA developed a website that is available to clients, community advocates, providers, and application assistance staff who work with the client population. The website provides information on medical program changes as they are being developed. Each AU will receive a letter advising which children are optional and their premium amounts.

Providers have received premium information through work groups and meetings held in several cities across the state. State staff convened community trainings in six cities and trained 700 providers and community members on the waiver changes. Some providers have indicated interest in sponsoring clients and have been involved in sponsorship planning and design. DSHS is prepared to collect premiums from sponsors, as sponsorships become available to clients.

Premiums will be reported on the CMS 64 quarterly, and will also be part of the quarterly waiver status report.

Premium Protections

DSHS will send invoices to the head of household monthly. The termination of the AU is proposed only when the AU is three months in arrears. A grace period for the monthly billing exists for that three-month period of time prior to actually becoming three months in arrears. Monthly billings that include a past due premium amount will provide the client with a warning that failure to pay can result in termination of eligibility. When an AU is three months in arrears, advance and adequate notice is mailed. During the advance and adequate notice period, payment in full will result in continued eligibility. Every letter proposing an adverse action includes text advising the client on her or his rights to an administrative fair hearing.

When full payment is made during the advance and adequate notice period, OFR sends ACES a computer-generated notice. ACES will automatically reenroll optional children in the AU when the AU has stayed open for mandatory children in the AU. If the AU is not already open, ACES will send the CSD assigned worker an electronic alert to reopen the case. If payment is made after the advance and adequate notice period, ACES inserts an electronic entry into the case "narrative". Should the household apply, information is visible and readily identifiable to the worker that the household has paid in full.

Outreach/Marketing/Education

Training information for eligibility workers in the CSOs includes a detailed overview of premium implementation, proposed premium bands and billing procedures. MAA also created an informational website to support premium education and training for eligibility workers, providers, clients, advocates and other stakeholders.

The children's benefits application and rack card will include premium information. Our 'Healthy Kids Now!' initiative partners distribute these materials statewide.

A notification letter and a question and answer sheet explaining premium rights and responsibilities will be sent to families with premiums. A statewide toll-free client line, with access to a contracted language translation services center, will support premium education.

Once found eligible for medical, clients with premiums will have access to an AnswerPhone giving real-time information about the status of premiums paid or still outstanding. Premium invoices will explain premium status and what that status means to maintain eligibility.

Training will continue to be offered as needed throughout the state for individuals who work directly with clients either in application assistance, determination of eligibility, or in providing medical services.

Premium information will be disseminated also to community stakeholder groups, i.e., the hospital association and advocate groups, as well as to other state agencies.

MAA has completed training for approximately 1,000 community services offices (CSO) staff, including regional trainers. Regional trainers have subsequently included a premium component in supplemental training classes. State staff has held more than fifteen seminars to educate interested public and providers.

Upon implementation, MAA will provide additional training (for trainers) at an ACES update seminar. The trainers will provide supplemental training to CSO workers. MAA will also make available an online manual of policy and procedures for premiums, as part of the overall eligibility policy manual, (http://www1.dshs.wa.gov/esa/eazmanual/) This manual is written for staff, but is also available to clients, providers and advocates. The premiums component will be added by June 15, 2004.

All written materials are translated into eight languages. For those individuals requesting the department communicate with them in a language other than those eight languages, explanatory materials will be offered in the individual's language of choice. DSHS provides interpreters when non-English speaking clients apply for Medicaid or when accessing medical services.

Over the last several months, when discussing future eligibility with clients, many eligibility workers are advising families to anticipate future premium requirements. Clients are advised that if the premium requirement applies to them, they will get written notice prior to implementation.

Eligibility/Enrollment

Clients eligible for the demonstration, in its current configuration, are children in the CN-0, non-grant program, in families with countable income above 150% and through 200% of FPL.

When new clients apply for medical benefits, eligibility workers in CSD assign workers Medicaid applications to process. Waiver clients will be notified that they will need to pay premiums. When an annual re-determination is due, ACES mails the designated review form to the client approximately 45 days before the review is due. The notification explains the adverse actions that will be taken should the client not respond to the review notice. If clients do not submit the required eligibility verification information when the review is due, or if the client is three months in arrears in premium payments, a termination letter is sent to the client. The termination letter advises the client of rights to a fair hearing.

Quality

Historically, Washington State has enjoyed a very low error rate for Medicaid eligibility determination. However, to further ensure that clients are entitled to the programs for which they have applied, the State now requires additional income verification and more frequent eligibility reviews for TANF, CN Pregnant Women, and CN Non-Grant Children. This increase in eligibility monitoring was implemented in April 2003.

MAA QA staff, within the Division of Medical Management, work with a cross-agency team, including a representative from CMS Region X, on Medicaid quality monitoring studies. If staff in DSHS, the Governor's Office, the Legislature, the Caseload Forecast Council, etc., observe unexpected trends in the numbers of clients eligible for medical programs, QA staff may be called upon to review field staff practices, conduct client surveys, or perform other monitoring activities as needed. Because Medicaid caseloads and expenditures are scrutinized on an ongoing basis, QA studies can be used as a basis for corrective action when appropriate.

Specific to the premium program, MAA will receive a number of monthly monitoring reports generated by ACES. Staff in DCS and DPA will be conducting monthly reviews of the ACES reports and using the data to produce the quarterly monitoring reports required by CMS.

Grievances and Appeals

The grievance and appeals process is the same for all TXIX-eligible clients.

Monitoring

In addition to the demonstration evaluation requirements set forth in Section 11.2 of the Special Terms & Conditions, DSHS will employ a set of on-going monitoring measures to assess the impact of adopting premiums for CN-0 children. These measures are intended to provide DSHS, CMS, Governor's Office of Financial Management (OFM), legislature health policy and appropriations committees, and stakeholders with information on the effects of premiums on the waiver population.

The monitoring measures will assess the program across four dimensions (see Attachment C). Existing studies and prevailing theory suggest that adopting premiums will reduce Medicaid coverage of affected children's eligibility groups. Families that

might otherwise have sought coverage for their children will elect to not enroll them because of the financial burden on the household.[1] Families with children currently enrolled will elect to drop coverage either due to affordability or a perception that their child does not need health care at this time.

DSHS will monitor the children's waiver population to assess whether there is a change in enrollment that might be attributable to premiums. The caseload will be monitored on a monthly basis with respect to changes in new enrollees, children exiting the program and the overall caseload (see Attachment D). These caseload parameters will be compared on a monthly basis with CN Mandatory children and CN-0 children who are not subject to premiums. The caseload comparisons will also include the State Children's Health Insurance Program (SCHIP) because its premium amounts are being changed (increased from $10 to $15 per-month) as part of adopting Medicaid premiums.

These comparisons will go back two years in time before the effective date (July 1, 2004) of the premiums to provide baseline trends. The measures will be updated on a monthly basis. The source of these data is the state's MMIS eligibility files. The Washington State Caseload Forecast Council (CFC) will generate these measures for DSHS.

In addition to the entry/exit caseload analysis, DSHS also will monitor caseload demographics (see Attachment E - Tables 2 - 7). The demographic monitoring will include: (1) distribution of children by their families' countable income used to determine eligibility; (2) distribution of children by family size; (3) distribution of children by their age; (4) distribution of children by their gender; (5) distribution of children by their reported race/ethnicity; and, (6) distribution of children by their families' primary language. The age distribution is based on age breaks used in the DSHS Healthy Options (HO) managed care capitation payment rate's age/gender risk adjuster.

The demographic parameters for the waiver population will be compared on a monthly basis with CN Mandatory children, CN-0 children who are not subject to premiums, and SCHIP. In order to generate the demographic comparison, DSHS will match CFC MMIS eligibility data with demographic information from ACES.

A second concern about adopting premiums is that they will cause adverse selection in the caseload's risk-profile. It is assumed those families enrolled in Medicaid and whose children are not using health care beyond the amount of their monthly premiums may elect to dis-enroll from Medicaid until such time as their child has an acute health care encounter. Families not enrolled in Medicaid will delay enrollment until such time as their child has an acute medical need. Thus, premiums could result in higher per-capita costs in the affected caseload.

[1] Washington's Medicaid premiums have been constructed so that a family will pay no more than one percent of their gross monthly income for coverage of their children.

Two recent experiences in Washington State parallel this initiative. First, the introduction of SCHIP included a premium requirement. Initial expectations were that significant adverse selection would result in a substandard risk pool. Proposals originally submitted by HO managed care plans included substantial margins to account for this expectation. The subsequent experience has proved much more favorable. Today, HO plans are paid for the SCHIP population using the same premium structure as for the Medicaid HO members.

A second example resulted from the transfer of the alien population (mostly what the state classified as V-Kids) from Medical Assistance eligibility to the state's Basic Health Program (BH). Only half of the eligible members elected to pay the BH premium, absorb the additional member cost sharing contained in the benefit plan design, and switch programs. However, later analysis indicated that no material adverse selection occurred during this process.

Based on these limited examples, the original hypothesis is that minimal adverse selection will result from requiring that the CN-0 and SCHIP populations pay premiums.

The introduction of member premiums to the CN-0 and SCHIP populations has the potential to create an environment that promotes adverse selection. 1 hat is, some segment of the subject population may make an economic decision that places other needs ahead of the purchase of medical coverage. Adverse selection results if those that are low-level consumers of services disproportionately reach this conclusion.

DSHS will contract with its consulting actuary (MillimanUSA) to conduct a risk-profile analysis to monitor this hypothesis using two separate analyses. The first involves the Chronic Illness and Disability Payment System (CDPS) created at the University of California - San Diego. The CDPS is a risk assessment tool that examines claim data, identifies the prevalence of chronic illness based on diagnosis coding, and computes a score that quantifies expected relative risk of a population. CDPS is tne standard risk assessment tool for the Medicaid population.

The CDPS model will be run for the CN-0 and SCHIP populations in six-month intervals to monitor how the risk score changes over time. The initial runs will be performed prior to the requirement of member premiums for these populations. At the same time, the Categorically Needy-Mandatory (CN-M) population will be similarly monitored as a study control group.

As mentioned above, the CDPS model evaluates the prevalence of chronic health problems in the target population. Chronic health problems are not the only potential source of adverse selection. In the absence of differences in chronic illness prevalence, clients can differ in their use of medical benefits. This can result from differences in personal lifestyle conduct that leads to acute medical needs or simp!y in the consumer mentality toward the use of medical resources.

The second analysis will examine utilization patterns of the CN-0 and SCHIP populations over time. Again at six-month intervals, summaries of member utilization based on a recent 12-month experience period will be accumulated and summarized by category of service. The CN-M population will again serve as the study control group.

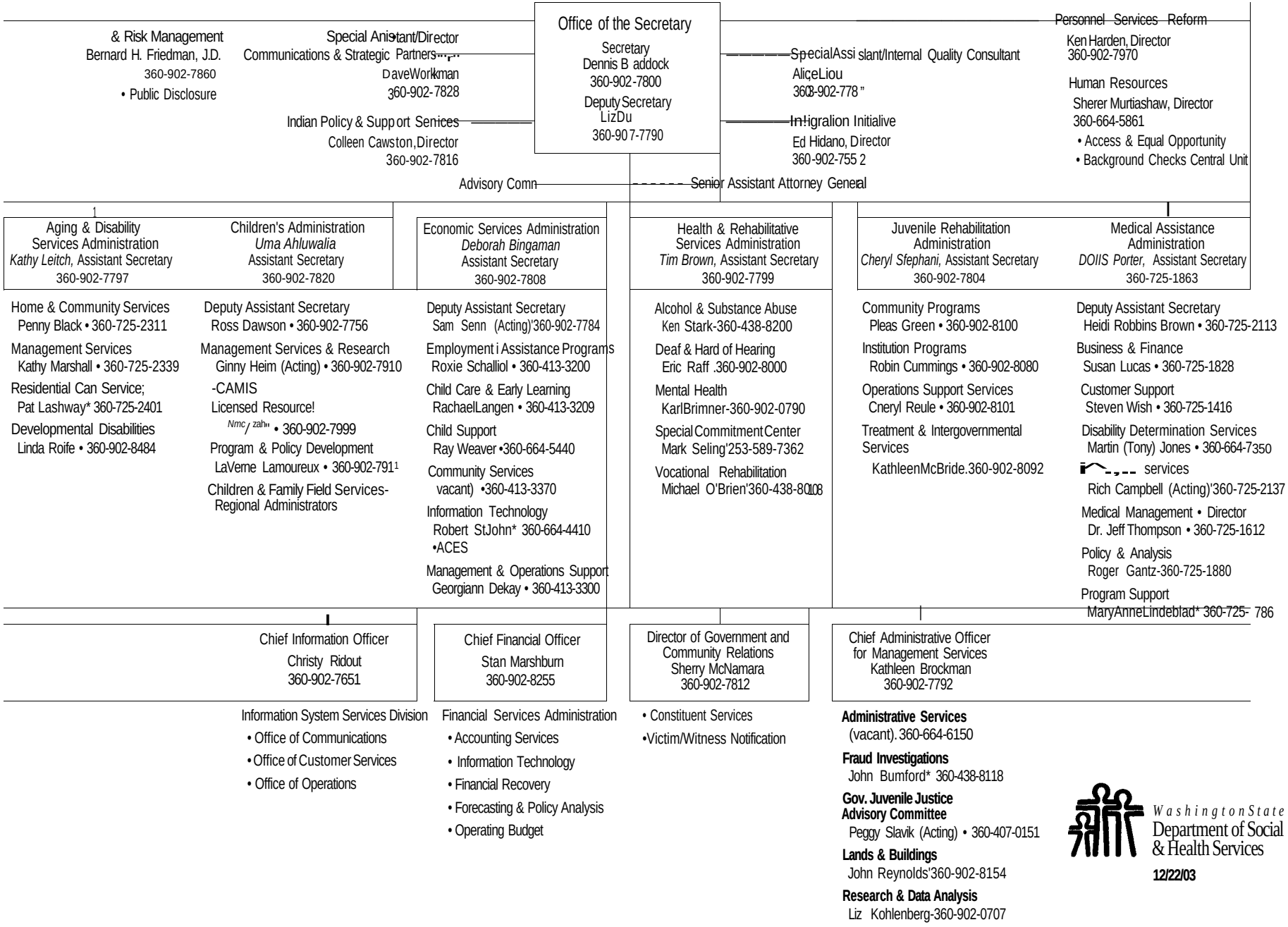
It is recognized that these two analyses are not independent. However, the expectation is that the two studies combined will provide a complete picture of the adverse selection that may result from the member premium requirement.

The models will rely on the encounter data being submitted quarterly by the participating health plans, as well as fee-for-service claim data and enrollment/eligibility data provided through the MMIS system. Each of these data elements is currently gathered on a regular basis for the computation of CDPS risk scores as part of the Healthy Options rate structure.

In addition to the assessment of the waiver population's acute and chronic care profile, DSHS will also track length of stay (LOS) on the caseload and return rates. If adverse selection is occurring, one would also expect that the average LOSon the program would be lower and that children would have a higher return rate than without premiums. These two measures will be tracked semi-annually with the adverse selection analysis.

Evaluation Design

DSHS will be submitting a detailed description of its proposed evaluation design. Unlike traditional demonstration evaluations that a'e to be completed 120 days prior to the expiration of the demonstration, DSHS' design will be a longitudinal design with at least two major reports. The draft design will be submitted to CMS by May 1, 2004.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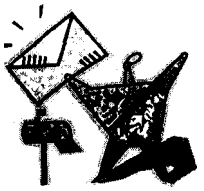

Your Medical Coverage May Change!

DSHS is making changes to medical coverage for children in the next few months. Those changes are:

- Medical coverage for children is now set for 6 months. You will be asked to fill out a review form every 6 months to see if your children can still get medical. If you do not fill out and return the form, your children may lose medical coverage.
- Changes in income now affect your children's eligibility. Please report when your household income changes by $100 or more a month.
- Starting February 2004, some families will be asked to pay a monthly premium for their children's medical coverage.

If you have to pay a premium for your children, you will receive a notice. Please wait for a notice. Your worker or call center will not be able to tell you if your children will have to pay a premium.

Attachment C - MEDICAID PREMIUM WAIVER MONITORING PARAMETERS

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Impact on CN optional and SCHIP children's monthly caseload trend.	Comparison of CN-0 and SCHIP caseload with prior year's caseload and current CN-M caseload	MMIS/CFC	Table 1	Monthly
Impact on CN optional children's caseload entry rate.	Comparison of CN-0 and SCHIP caseload with prior year's caseload and current CN-M caseload	MMIS/CFC	Table 1	Monthly
Impact on CN optional children's caseload exit rate.	Comparison of CN-0 and SCHIP caseload with prior year's caseload and current CN-M caseload	MMIS/CFC	Table 1	Monthly
DEMOGRAPHIC IMPACT	COMPARISON ANALYSIS	DATA SOURCE [2]	[illegible]	[illegible]
Impact on income distribution of CN optional children's caseload.	Comparison of CN-0 and SCHIP Caseload with prior year's and current CN-M caseload	CFC/ACES	Table 2	Monthly
Impact on premium family size of CN optional children's caseload.	Comparison of CN-0 and SCHIP Caseload with prior year's and current CN-M caseload	CFC/ACES	Table 3	Monthly
Impact on age of CN optional children's caseload.	Comparison of CN-0 and SCHIP Caseload with prior year's and current CN-M caseload	CFC/ACES	Table 4.A Table 4.B Table 4.C	Monthly
Impact on gender of CN optional children's caseload.	Comparison of CN-0 and SCHIP Caseload with prior year's and current CN-M caseload	CFC/ACES	Table 5	Monthly
Impact on race/ethnicity of CN optional children's caseload	Comparison of CN-0 and SCHIP Caseload with prior year's and current CN-M caseload	CFC/ACES	Table 6	Monthly
Impact on primary language of CN optional children's caseload.	Comparison of CN-0 and SCHIP Caseload with prior year's and current CN-M caseload	CFC/ACES	Table 7	Monthly

' Caseload Forecast Council (CFC) will generate this data as part of their monthly caseload monitoring function.
[2] DSHS RDAD will generate this data as part of intra-agency agreement with MAA.

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MEDICAID PREMIUM WAIVER MONITORING PARAMETERS

IMPACT			
Impact on chronic risk profile of CN optional and SCHIP caseload.	Comparison of CN-0 and SCHIP caseload prior to premium implementation with current caseload and with prior and current CN-M caseload	Chronic Illness & Disability Payment System (CDPS)	Bi-Annual
Impact on acute risk profile of CN optional and SCHIP caseload.	Comparison of CN-0 and SCHIP medial expenditures during the first two months and last two months pre and post premium implementation	MMIS/HO Encounter Data	Bi-Annual
Impact on CN optional children's caseload return rate.	Comparison of CN-0 and SCHIP caseload with prior year's caseload and current CN-M caseload	MMIS/CFC	Bi-Annual
Length of stay (LOS) on the program	Comparison of CN-0 and SCHIP LOS with prior year's and current CN-M caseload	MMIS/CFC	Bi-Annual
PROCESS			
Reasons CN optional and SCHIP children's families stopped paying premiums and children's coverage was terminated.		**Follow-up telephone survey and** possible **focus** groups	To Be Determined

[3] This analysis will be performed by MillimanUSA, MAA's consulting actuary.
^DSHS RDAD will generate this data as part of intra-agency agreement with MAA.

Attachment D - TABLE 1

MEDICAID & SCHIP PREMIUM CASELOAD ANALYSIS

children				CN 1055 Optional Children Below 150% FPG										CN 1055 Optional Children Above 150% FPG										1150 SCHIP Children									
		Caseload		Entries			Exits			Casebad		Entries			Exits			Caseload		Entries			Exit.			Caseload	
·A e	Exit Bate	Number	Percent Change	Number	Percent Change from Prior Monih	Entry Rate	Number	Percent Change from Prior Month	EMI Rate	Number	Percent Change	Number	Percent Change from Prior Month	Ertify Rate	Number	Percent Change from Prior Month	Exit Rate	Number	Percent Change	Number	Percent Change from Prior Month	Entry Rate	Number	Percent Change from Prior Month	Exit Rate	Number	Percent Change

asfs. The data source Is MMIS IER eligibility data. There will be a 3-month data-lag)

Attachment E - TABLE 2

MEDICAID & SCHIP PREMIUM DEMOGRAPHIC ANALYSIS - FAMILY COUNTABLE INCOME DISTRIBUTION

Month	CN 1055 Mandatory Children's Caseload												CN 1055 Optional Children's Caseload Below 150% FPG				CN 1055 Optional Children's Caseload Above 150%FPG				1150 SCHIP Children's Caseload			
	0%-50% FPG		51%-100%FPG		101%-125%FPG		126%-150%FPG		151%-175% FPG		176%-200% FPQ		101%-125%PFG		126%-150%FPG		151%-175% FPG		176%-200% FPQ		201%-225% FPG		226%-250% FPG	
	Number	Percent of Total CN-M Population	Number	Percent of Total CN-M Population	Number	Percent of Total CN-M Population	Number	Percent of Total CN-M Population	Number	Percent of Total CN-M Population	Number	Percent of Total CN-M Population	Number	Percent of Total CN-0 Pop Below 150%	Number	Percent of Total CN-0 Pop Below 150%	Number	Percent of Total CN-0 Pop Above 150%	Number	Percent of Total CN-0 Pop Above 150%	Number	Percent of Total SCHIP Population	Number	Percent of Total SCMIP Popula'i on
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NOTE: This report will be generated by DSHS-RDAD on a monthly basis. The data sources are CFC MMIS IER eligibility data and DSHS ACES demographic data. There will be a 3-month data-lag.)

Attachment E - TABLE 3
MEDICAID & SCHIP PREMIUM DEMOGRAPHIC ANALYSIS - PREMIUM CASE SIZE

Month	CN 1055 Mandatory Children's Caseload						CN 1055 Optional Children's Caseload Below 150% FPG						CN 1055 Optional Children's Caseload Above 150% FPG						1150 SCHIP Children's Caseload					
	1 Child		2 Children		3 or More Children		1 Child		2 Children		3 or More Children		1 Child		2 Children		3 or More Children		1 Child		2 Children		3 or More Children	
	Number	Percent of Total CN-M Population	Number	Percent of Total CN-M Population	Number	Percent of Total CN-M Population	Number	Percent of Total CN-0 Pop Below 150%	Number	Percent of Total CN-0 Pop Below 150%	Number	Percent of Total CN-0 Pop Below 150%	Number	Percent of Total CN-0 Pop Above 150%	Number	Percent of Total CN-0 Pop Above 150%	Number	Percent of Total CN-0 Pop Above 150%	Number	Percent of Total SCHIP Population	Number	Percent of Total SCHIP Population	Number	Percent of Total SCHIP Poputo-tion
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NOTE: This report will be generated by DSHS-RDAD on a monthly basis. The data sources are CFC MMIS IER eligibility data and DSHS ACES demographic data. There will be a 3-month data-lag)

Attachment E - TABLE 4

MEDICAID & SCHIP PREMIUM DEMOGRAPHIC ANALYSIS - CHILD'S AGE

Month	CN 1055 Mandatory Children's Caseload								CN 1055 Optional Children's Caseload Below 150% FPQ								CN 1055 Optional Children's Caseload Above 150% FPG								1150 SCHIP Children's Caseload							
	< 1		1 -2		3-14		15-18		< 1		1 -2		3- 14		15.18		< 1		1 -2		3-14		15-18		< 1		1 -2		3-14		15-18	
	Number	Percent of Total CN-M Population	Numbtf	Percent of Total CN-M Population	Number	Percent of Total CN-M Population	Number	Percent of Total CN-M Population	Numbtf	Percent of Total CN-0 Pop Below 150%	Number	Percent of Total CN-0 Pop Below 150%	Number	Pal-cent of Total CN-0 Pop Below 150%	Number	Percertof Total CN-0 Pop Betow 150%	Number	Percent of Total CN-0 Pop Above 150%	Number	Percertof Total CN-0 Pop Above 150%	Number	Percertof Total CN-0 Pop Above 150%	Number	Percortol Total CN-0 Pop Above 150%	Number	Percertof Total SCHIP Population	Number	Percent of Total SCHIP Population	Number	Percent of Total SCHIP Population	Number	Percent of Total SCHIP Population
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(NOTE: This report will be generated by DSHS-RDAO on a monthly basis. The data sources are CFC HMIS KR eligibility data and DSHS ACES data. There will be a 3-month data lag.)

Attachment E - TABLE 4

MEDICAID & SCHIP PREMIUM DEMOGRAPHIC ANALYSIS - CHILD'S AGE

Month	CN 1055 Mandatory Children's Caseload								CN 1055 Optional Children's Caseload Below 150% FPQ								CN 1055 Optional Children's Caseload Above 150% FPG								1150 SCHIP Children's Caseload							
	< 1		1 -2		3-14		15-18		< 1		1 -2		3- 14		15.18		< 1		1 -2		3-14		15-18		< 1		1 -2		3-14		15-18	
	Number	Percent of Total CN-M Population	Numbtf	Percent of Total CN-M Population	Number	Percent of Total CN-M Population	Number	Percent of Total CN-M Population	Numbtf	Percent of Total CN-0 Pop Below 150%	Number	Percent of Total CN-0 Pop Below 150%	Number	Pal-cent of Total CN-0 Pop Below 150%	Number	Percertof Total CN-0 Pop Betow 150%	Number	Percent of Total CN-0 Pop Above 150%	Number	Percertof Total CN-0 Pop Above 150%	Number	Percertof Total CN-0 Pop Above 150%	Number	Percortol Total CN-0 Pop Above 150%	Number	Percertof Total SCHIP Population	Number	Percent of Total SCHIP Population	Number	Percent of Total SCHIP Population	Number	Percent of Total SCHIP Population
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(NOTE: This report will be generated by DSHS-RDAO on a monthly basis. The data sources are CFC HMIS KR eligibility data and DSHS ACES data. There will be a 3-month data lag.)

TABLE 4.8
MEDICAID & SCHIP ELIGIBILITY & PREMIUM DEMOGRAPHIC ANALYSIS - FEMALE CHILD'S AGE

Month	CN 1055 Mandatory Children's Caseload									CN 1055 Optional Children's Caseload								1150 SCHIP Children's Caseload							
	< 1		-2		3 - 14		15- 18			< 1		1 - 2		3 - 14		15- la		< ▮		1 - 2		3 - 14			
	Number	Percent Change from Prior Month	Number	Pereert Change from Prior Month	Number	Percent Change from Prior Month	Number	Percent Change from Prior Month		Number	Percent Change from Prior Month	Number	Percent Change from Prior Month	Number	Percent Change from Prior Month	Number	Pefcent Change from Prior Month	Number	Percent Change from Prior Month	Number	Percent Change from Prior Month	Number	Percent Change from Prior Month	Number	Percent Change from Prior Month
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Ftb-06																									
Mar-06																									
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May-06																									
Jun-06																									

TABLE 4.C
MEDICAID & SCHIP ELIGIBILITY & PREMIUM DEMOGRAPHIC ANALYSIS - MALE CHILD'S AGE

Month	CN 1055 Mandatory Children's Caseload									CN 1055 Optional Children's Caseload								1150 SCHIP Children's Caseload							
	< 1		\ -2		3- 14		15-18			< I		1 - 2		3 - 14		15-18		< 1		1 - 2		3 - 14		15 - 18	
	Number	Percent Change from Prior Month	Number	Percent Change from Prior Month	Number	Percent Change from Prior Month	Numbar	Pereert Change from Prior Month		Number	Percent Change from Prior Month	Number	Percent Change from Prior Month	Number	Percent Change from Prior Month	Number	Percent Change from Prior Month	Number	Percent Change from Prior Month	Number	Percent Change from Prior Month	Number	Percent Change from Prior Month	Number	Percent Change from Prior Month
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Attachment E - TABLE 5

MEDICAID & SCHIP PREMIUM DEMOGRAPHIC ANALYSIS - CHILD'S GENDER

Month	CN 1055 Mandatory Children's Caseload				CN 1055 Optional Children's Caseload Below 150% FPG				CN 1055 Optional Children's Caseload Above 150% FPG				1150 SCHIP Children's Caseload			
	Female		Male		Female		Male		Female		Male		Female		Male	
	Number	Percent of Total CN-M Population	Number	Percent of Total CN-M Population	Number	Percent of Total CN-0 Pop Below 150%	Number	Percent of Total CN-0 Pop Below 150%	Number	Percent of Total CN-0 Pop Above 150%	Number	Percent of Total CN-0 Pop Above 150%	Number	Percent of Total SCHIP Population	Number	Percent of Total SCHIP Population
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(NOTE: This report will be generated by DSHS-RDAD on a monthly basis. The data sources are CFC MMIS IER eligibility data and DSHS ACES data. There will be a 3-month data lag.)

AHachment E • TABLE 6

MEDICAID & SCHIP PREMIUM DEMOGRAPHIC ANALYSIS - CHILD'S RACE/ETHNICITY

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Attachment E - TABLE 7

MEDICAID & SCHIP PREMIUM DEMOGRAPHIC ANALYSIS - CHILD'S HOUSEHOLD PRIMARY LANGUAGE

Month	CN<055 Mandatory Cfilldren'x Caseload		5o==								CN 1055 Option*1 Children's Caselojid Below 150% FPG										CN 1055 Optlona Chlhfren'S Caseload Above 150%FPQ										1150 SCHIP Chlldren'B Caseload									
	Number	Parconlot Total CN-M PopufaSon	Numbar	Percent o(Total CN-M Population	Number	Peroentof ToUCN-M PcpulaHoo	Number	Percent of Tola) CN-M Population	Number	Par-cent of Total CN-M Reputation	Number	Paicentof Total CN-0 PopBalow 150%	Numbw	PBfCWilOf TotdC^O PopSalow	Numbar	Pwcanlcil Total CN-0 PopBetow 150%	Number	Percent of Totd CN-0 Pop Below 150%	Number	Percanlof TotelCN-0 Pop Below 150%	Number	Percent of TobdCN-0 PopAbow 150%	Nuniber	Peroentot TotriCN-0 PopAbow 150%	Number	Perconlor ToMCN-0 PopAbow	Number	ParoafHof Tori CN-0 PopAbow 150%	Number	Percent o(Total CN-0 Pop Above 150%	Number	Pafcentof Total SCH1P Popilafan	Number	Percent of Total SCHIP Population	Number	Porcanlof Total SCHIP Population	Number	Percent of Total SCHIF Popubljon	Number	Pereantof Total SCHIP Population
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